INSTRUCTIONS FOR COMPLETING
DYSPHAGIA/ASPIRATION SCREENING TOOL

1. **General Instructions:** A nurse (RN or LPN), eating specialist (SLP, OT, PT) or physician should fill out this screening tool after they have become familiarized with the individual to be screened. This familiarization with the individual after a meal, talking to direct support staff, home-based provider, day hab staff, guardians and/or physicians.

2. The screening tool needs to be completely answered. "Yes" answers only are recorded. Each answer is weighted and the score should be marked in the score column after the question is answered "Yes". In order to be certain that every question was asked; if the answer was "No" to the question, write "0" in the score column. Each section score is then totaled and a final total is computed on this instruction sheet. If the information is unknown, the individual doing the screening needs to find a person who can accurately answer the question so that no questions are omitted.

Functional Assessment Score	_____
Anatomy & Physiology Score	_____
Nutritional Assessment	_____
Medication Assessment	_____
Medical Assessment	_____
Dental Assessment	_____
Total Score	_____

If the total score is greater than 65, the individual needs to be screened for dysphagia (swallowing disorder) and aspiration.

3. After the score is tallied, the individual either is "negative" or "positive" for signs and symptoms of dysphagia and risk for aspiration. Those found to be at risk should be referred to their PCP to determine what actions need to be taken next.

This form was adapted from the New Mexico Department of Health Dysphagia/Aspiration Screening Tool

DYSPHAGIA/ASPIRATION SCREENING TOOL

Last Name:	**First Name:**	**Date of Birth: / /**
Name of Reviewer:		**Review Date: / /**
Has this person ever had a swallowing evaluation? ☐ **Yes** ☐ **No** ☐ **Unknown**		
If Yes, Date of Eval: / /	**Findings:**	

	FUNCTIONAL ASSESSMENT	WEIGHT	YES	SCORE
1.	Does the person have severe to profound Mental Retardation?	2		
2.	Does the person have dementia?	2		
3.	Does the person require assistance with feeding?	2		
4.	Does the person require special seating when eating?	2		
5.	Does the person need help with head control during eating?	3		
6.	Does the person require adaptive equipment during mealtime?	3		
7.	Does the person have quadraparesis?	1		
8.	Is the person recumbent > 50% of the day?	1		
		TOTAL		

	ANATOMY AND PHYSIOLOGY ASSESSMENT	WEIGHT	YES	SCORE
ANATOMY				
1.	Does the person have any head/neck abnormalities which affect chewing or swallowing?	3		
If yes, what is the abnormality?				
2.	Does the person have missing teeth affecting eating?	1		
3.	Does the person have periodontal disease affecting eating?	2		
4.	Does the person have eating problems associated with dentures?	2		
PHYSIOLOGY				
1.	Does the person not close their lips during eating?	2		
2.	Does the person not chew their food?	2		
3.	Does the person pocket food in their mouth/cheeks during eating?	2		
4.	Does the person lose food or liquids from their mouth during eating?	2		
5.	Does the person have difficulty initiating swallowing?	3		
6.	Does the person's voice change during eating?	3		
7.	Does the person gag, cough or choke while eating?	3		
8.	Does the person gag, cough or choke 1-2 hours after eating?	3		
9.	Does the person have refluxed food in their mouth > ½ hour after eating?	3		
10.	Does the person take very large bites or overfill their mouth when eating?	2		
11.	Does the person drool when not eating?	1		
12.	Does the person eat very rapidly?	2		
13.	Does the person have a gurgly sound in their throat while breathing?	3		
14.	Does the person make wheezing noises during or after eating?	3		
15.	Does the person ruminate?	2		
		TOTAL		

	NUTRITIONAL ASSESSMENT	WEIGHT	YES	SCORE
1.	Is the person below their recommended weight range?	2		
2.	Has the person had unintentional weight loss during the past 6 months? (10% loss of previous weight over past 3 months or 15% loss over past 6 months?)	3		
3.	Does the person take longer than 60 minutes to eat?	3		
4.	Does the person refuse to eat at times?	2		
If yes, what % of the time?				
5.	Is the person combative during a meal?	3		
6.	Has the person suffered dehydration requiring medical attention?	3		
7.	Does the person require a modified diet for food or liquid consistency?	3		
8.	Does the person have a nutritional plan?	2		
9.	Does the person use liquid supplements such as Ensure or Resource?	2		
			TOTAL	

	MEDICATION ASSESSMENT	WEIGHT	YES	SCORE
1.	Does the person take allergy medications?	2		
2.	Does the person take psychotropic medications?	3		
3.	Does the person take antiseizure medications?	3		
4.	Does the person take asthma medications?	2		
5.	Does the person take medications for GERD?	2		
6.	Do any of the medications cause drowsiness, sedation or somnolence?	3		
7.	Do any of the person's medications cause dry mouth?	2		
8.	Do any of the medications need crushing or need to be in liquid form due to difficulty swallowing?	3		
TOTAL				

	MEDICAL ASSESSMENT	WEIGHT	YES	SCORE
1.	Has the person had recurrent bronchitis in the past year?	3		
2.	Has the person had pneumonia in the past year?	3		
3.	Does the person have asthma?	3		
4.	Has the person been diagnosed with GERD?	3		
5.	Does the person require supplemental oxygen?	3		
6.	Is the person experiencing a significant decline in their cognitive skills?	2		
7.	Has the person been intubated in the past year?	3		
8.	Does the person have a progressive neurodegenerative process such as multiple sclerosis, dementia, or neuropathy?	2		
9.	Has the Heimlich maneuver ever been used with the person?	3		
10.	Has the person ever experienced a severe choking episode?	3		
			TOTAL	

	DENTAL ASSESSMENT	WEIGHT	YES	SCOR

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1.	Does the person require a 2-person assist with tooth brushing?	2		
2.	Does the person have food debris discovered in their mouth when their teeth are bushed?	2		
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